Illinois Department of Public Aid

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INFORMATIONAL NOTICE

TO: Participating Medical Assistance Providers

RE: Billing Requirements for Diagnostic Services

Effective immediately, the department will require providers to submit both modifiers TC (technical component) and 26 (professional component) when billing for global reimbursement of a diagnostic procedure code. In order to ensure that the appropriate reimbursement is made, please follow the billing instructions outlined below.

Paper Claims
To receive global reimbursement for diagnostic procedure codes, providers must report the appropriate procedure code and modifier 26 on one service line and report the same procedure code and modifier TC on another service line.

National Standard Format (NSF) Electronic Claims
To receive global reimbursement for diagnostic procedure codes, providers must report the appropriate procedure code and modifiers 26 and TC both in the Claim Detail.

HIPAA 837P Electronic Claims
To receive global reimbursement for diagnostic procedure codes, providers must report the appropriate procedure code and modifiers 26 and TC both in Loop 2400.

Professional or Technical Component Only
Claims submitted on paper or electronically for the technical or professional component only must contain the procedure code and modifier 26 or TC, as applicable.

Any questions regarding this notice should be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

Anne Marie Murphy, Ph.D.
Administrator
Division of Medical Programs